

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 279

STATE FILE NUMBER 63-035312

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

8147

26760

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9/95.1

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DATE AMENDED

10/15/63

INSTEAD OF

SHOULD READ

Inanition due to carcinoma of thyroid

DOCUMENT

BY AFFIDAVIT OF attending physician

FILED OCT 1 1963

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Osage</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Fulton</u>		c. CITY OR TOWN <u>Koeltz town</u>	
Length of stay in 1b <u>2y-4mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #1</u>		d. STREET ADDRESS (If outside, give location) <u>Koeltz town</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>NILGES</u> Last <u>NILGES</u>		4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1963</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-26-09</u>
9. AGE (last birthday) <u>53</u>		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (City and state or country) <u>Fresburg Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ben Holterman</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Hoffman</u>	
14. NAME OF HUSBAND OR WIFE <u>Frank Nilges</u>		Address <u>Koeltz town Mo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Frank Nilges</u>	
17. INFORMANT <u>Frank Nilges</u>		Address <u>Koeltz town Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia due to interstitial INANITION - calzinosis of heart, lung and kidneys due to functional carcinoma of CARCINOMA OF THYROID parathyroid.</u> DUE TO (b) <u>6 MON</u> DUE TO (c) <u>6 MON</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>12:40 AM</u> a.m. p.m.	Month, Day, Year <u>5/25/61</u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>State Hosp #1</u>	20f. CITY, TOWN, OR LOCATION <u>State Hosp #1</u>	COUNTY <u>Osage</u> STATE <u>MO</u>
21. I attended the deceased from <u>5/25/61</u> to <u>9/28/63</u> and last saw her alive on <u>9/21/63</u> Death occurred at <u>12:40 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>G.B. Jackson MD</u>		22b. ADDRESS <u>State Hosp. #1</u>	
22c. DATE SIGNED <u>9/28/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 1, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>H. Boniface</u>	23d. LOCATION (City, town, or county) (State) <u>Koeltz town MO</u>
24. FUNERAL DIRECTOR <u>Dulle</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 28 - 1963</u>	26. REGISTRAR'S SIGNATURE <u>M. Lawrence</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James E. Eynard

Licensed Embalmer No. 4978

P.O. Address Jeff City Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.